Aesth Plast Surg (2014) 38:1177–1183
DOI 10.1007/s00266-014-0409-0

The Role of Mental Health Professionals in Gender Reassignment Surgeries: Unjust Discrimination or Responsible Care?

Gennaro Selvaggi · Simona Giordano

Received: 25 March 2014 / Accepted: 29 September 2014 / Published online: 25 October 2014

Abstract
Objective Recent literature has raised an important ethical concern relating to the way in which surgeons approach people with gender dysphoria (GD): it has been suggested that referring transsexual patients to mental assessment can constitute a form of unjust discrimination. The aim of this paper is to examine some of the ethical issues concerning the role of the mental health professional in gender reassignment surgeries (GRS).
Method The role of the mental health professional in GRS is analyzed by presenting the Standards of Care by the World Professional Association of Transgender Health, and discussing the principles of autonomy and non-discrimination.
Results Purposes of psychotherapy are exploring gender identity; addressing the negative impact of GD on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; promoting resilience; and assisting the surgeons with the preparation prior to the surgery and the patient's follow-up. Offering or requesting psychological assistance is in no way a form of negative discrimination or an attack to the patient's autonomy. Contrarily, it might improve transsexual patients' care, and thus at the most may represent a form of positive discrimination. To treat people as equal does not mean that they should be treated in the same way, but with the same concern and respect, so that their unique needs and goals can be achieved.
Conclusions Offering or requesting psychological assistance to individuals with GD is a form of responsible care, and not unjust discrimination.
Level of Evidence V This journal requires that authors assign a level of evidence to each article. For a full description of these Evidence-Based Medicine ratings, please refer to the Table of Contents or the online Instructions to Authors www.springer.com/00266.

Keywords Gender dysphoria · Gender reassignment surgeries · Transsexualism · Medical ethics · Mental health professional

Introduction

In a recent paper, Latham [1] has raised an important ethical concern relating to the way in which healthcare professionals, particularly surgeons, approach people with gender dysphoria (GD), who seek gender reassignment surgery[1]

G. Selvaggi (✉)
Department of Plastic Surgery, Institute of Clinical Sciences, Sahlgrenska Academy, Sahlgrenska University Hospital, University of Gothenburg, Gröna Stråket 8, 41345 Gothenburg, Sweden
e-mail: selvaggigennaro@yahoo.it

S. Giordano
Reader in Bioethics, CSEP/iSEI, The School of Law, The University of Manchester, Williamson Building, Oxford Road, Manchester M13 9PL, UK
e-mail: simona.giordano@manchester.ac.uk

[1] There are various other ways of referring to similar procedures: "gender reaffirming" surgery, "gender confirming" surgery, "sex reassignment surgery," and "gender realignment" surgery are the most common. Some terms, such as "confirming" or "realignment," seem to suggest that perceived gender is innate, and surgery is meant to re-align the body to the "real" gender of the person. We will not examine in great detail the terminological issues; partly, people's preference for one term rather than the other depends on views relating to how gender identity develops. For theories on gender identity development, see Giordano S, Children with Gender Identity Disorder, Routledge, 2012, Chapter 2. For ease, in this paper, we opt for "gender reassignment surgery." We opt for "gender" rather than "sex," because the latter refers to the genital area only.

and other gender-confirming medical procedures.[2]

Latham argues that people who seek these procedures because of GD are compulsory referred to undertake mental assessment. Those without GD who apply for, according to Latham, *the same* procedures, are not (or extremely rarely are) subjected to the same mental assessment. This is a form of unjust discrimination toward patients with GD [2].

Latham goes further: he seems to suggest that such discrimination takes place because the requests of people with GD violate social norms. He argues that if a woman requests a surgical procedure (for example, breast enlargement) that is coherent with social norms (women should have breasts), she will not be subjected to psychiatric assessment *because* her request is coherent with social norms; she will, instead, if her requests violate such social norms (for example, if she asks for radical, that is complete, breast removal). The person with GD has desires that do not conform to social norms, and this, Latham seems to suggest, is why s/he will be required to undergo mental assessment prior to being considered for surgery.

In other words, Latham seems to suggest that some gender stereotypes (for example, wanting breasts of a certain type is "normal" for women) and norms of social acceptability (a woman should conform to certain standards of beauty in order to be socially accepted [3, 4]) drive, somehow unrecognized, the care of people with GD.

At first sight, Latham's arguments sound compelling, and they certainly raise important ethical questions. If it were true that inherent to medical practice lay norms of social acceptability, and a discriminatory attitude toward people with GD, there would undoubtedly be strong ethical reasons to think carefully about the healthcare practices (not only surgical) offered to this population of patients. The paradox here is particularly acute, as this area of medicine should have at its core the recognition of different gender identities.

Although Latham's [1] concerns are important, and his arguments seem at first sight compelling, at further scrutiny, they appear simplistic at best, and potentially harmful to patients (not only to the transsexual patients) at worse.

[2] Wherever possible, we shall privilege the terms "medical interventions" and "medical procedures" over the terms "medical treatments" or "therapies", in that they might imply a difference between these and "cosmetic" procedures. The terms "procedures" or "interventions," in fact, would apply to all areas of medical care. We shall also refer particularly to surgery, but what is said is also relevant to other areas of healthcare for people with GD.

Not All the Same Surgery is the Same

The idea at the core of Latham's argument [1] is that many medical procedures used in the treatment of patients with GD *are the same* as those used in the treatment of other patients: a mastectomy is a mastectomy, whoever requests it and for whatever reason it is requested.

Latham is irrefutably right in this: many clinical procedures used to help people with GD are *technically* the same as those used in other contexts.

But it does not follow from the fact that technically the procedure is analogous, that also their purposes are the same, and that the hopes and expectations of the patients are the same, or that the repercussions in the life of the patients are the same. Even less it follows that because technically the procedure is the same, then all patients need to be treated in the same way regardless of why they request the procedure.

Indeed, it is a gross misunderstanding of the principle of equality to interpret it as requesting that people ought to be treated *in the same way*. People need to be treated *differently*, so that they can all *equally* be helped to achieve their own goals. Medicine ought to, at the very least, minimize people's suffering: but in order to do that, the specific predicaments unique to each individual must be understood. In other words, to *equally* alleviate people's suffering, people ought to be treated with equal concern and respect, and to be given an equal opportunity to attain a healthy life: to do this, they need to be treated *differently* [5].

The Complexities Inherent to Gender Treatment

Some would object to Latham's argument that the same medical procedure (for example, mastectomy) could be either cosmetic or therapeutic, and patients who need a treatment cannot be treated in the same way as patients who want to ameliorate their look.

Determining what constitutes "therapeutic" versus "cosmetic" procedures raises important philosophical issues. In this paper, we purposely avoid discussing the issue of how medical interventions should be classified, and what it is that makes them "cosmetic" rather than "therapeutic." We refer the interested reader to other sources, such as Sterodimas et al. [6] and Edmonds [7], which are representative of the ongoing discussion. Further, we are currently preparing a parallel paper focusing on this issue in relation to gender treatments.

What matters to the purposes of this paper is not so much determining what procedures can be classified as cosmetic rather than therapeutic, but the fact that GD carries with itself complexities that are probably unique to the condition [8, 9].

The person who applies for gender reassignment usually has a long history of discomfort [10], and the suffering associated with GD is all encompassing: it includes intrapsychic suffering [11] (often from adolescence or even earlier), but also relational suffering: it includes discrimination, alienation, bullying, and severe social ostracism [12, 13].

Transsexual people are among the most violated, humiliated, and abused of all minorities: some of the most violent and atrocious crimes are those perpetrated against them [12]. Suicidal ideation and suicide attempts among people with GD are very high [14, 15].

The constellation of difficulties associated with GD complicates enormously the clinical picture of a person who applies for medical intervention, as compared with the population of patients who request medical or surgical procedures for purposes that are not gender related [16].

Gender-related procedures have an impact upon the whole life of the patient, which is not necessarily comparable with procedures, even of the same kind, performed on other categories of patients.

It follows that even if, technically, a medical intervention is the same, when that intervention is required because of GD there are usually concerns that may not be present in other cases, or that are likely to be different from those present in other cases. To make a clear example, a breast enlargement in a woman with small breast, a breast enlargement in a transsexual woman, a mastectomy in a cancer patient, and a mastectomy in a transsexual patient may be similar procedures, technically speaking, but the impact and meaning of that procedure in each case are likely to be profoundly different; the expectations of the patients may also be markedly different. Doctors may have important clinical and ethical reasons to involve mental health professionals in all cases (whether or not the requests come from GD patients); and if in many cases, requests are not subjected to further scrutiny, it does not follow that they should not be subjected to further scrutiny in all cases.

Moreover, the medical procedures offered for gender issues are also particularly complex. Various options can be offered to people with GD, such as hormonal therapy, psychological and social support, and different surgeries. Further, even within surgery, the approaches are various and lead to different results both at functional and appearance levels; for example, for penile reconstruction, a metaidoioplasty is not as invasive as a radial forearm phalloplasty [17–20]. Surgery is perhaps the ultimate and most radical step in the process of gender reassignment, and follows usually other medical procedures, and a long-term clinical process, during which the person's concerns and response to various medical procedures are assessed and addressed. See for example, the female-to-male transsexual wish for urinating via the penis or the desire for penetrative sexual intercourse [17, 18]. Surgery is the quintessential goal for many, as it provides the appropriate physical morphology and alleviates the *extreme* psychological discomfort of the patient [21–23].

Data on suicidal behavior pre- and post-surgery confirm significantly less suicidal ideation and attempts in patients after reassignment [24, 25].

Genital surgery has a huge impact on the social life of the patient, and the assessment of the results of the surgery goes far beyond the fact that the intervention was eventful or uneventful. To assess the outcome of the surgery, in patients with GD, at least all the following needs to be evaluated: if functional expectations have been met, if social expectations have been met, and to what extent the presence of complications has prevented the patient from meeting functional and/or social expectations. For example, has the female-to-male transsexual patient following mastectomy been able to pass as a man, and therefore feels comfortable in social situations such as at swimming pools or at the gym? Does the male-to-female transsexual patient feel that her facial feminization surgery fulfilled her expectations when relating to society? How important are functions such as urinating while standing, sexual intercourse, cosmetic appearance of the phallus, absence of donor site morbidity and unsightly scars, for a female-to-male transsexual patient planning phalloplasty? As a consequence, the surgeon may reasonably and legitimately request the help of a mental health professional to assist transsexual patients with such complex evaluations both prior and after any procedure is offered. More specifically, surgeon and patient can use the advantage of mental health expertise to better understand each other, and the patient can better understand his/her wishes and the impact of surgery in his/her life.

We also need to remember that for individuals seeking care for GD, a variety of options may be considered: not only surgery, but changes in gender expression and role, or hormone interventions. Surgery can be partial or total; many transsexual people may want, for example, breast surgery and their genitals intact and, according to the Standards of Care (SOC) of the World Professional Association for Transgender Health (WPATH), having a partial surgical treatment can be beneficial to the group of patients who decide to go for it [21]. The implication for surgeons is that surgeons should accept the patients' request for surgery limited to only part of the body (e.g., only breast and not genitals; or only genitals and not breast"); further, surgeons should possibly advise and refer patients to mental health professionals to help to understand their desires. The mental health professional might help the person to understand the nature of his/her concerns; assist patients in exploring their gender identity; help with

distress usually associated with GD but secondary to it (such as depression, anxiety, isolation); provide family counseling; and help to ameliorate any other psychosocial difficulties; finally, the mental health professional may help the surgeon to understand what types of medical interventions are most likely to benefit the patient. The mental health professional may also assess and address any co-existing mental health concerns; educate and advocate on behalf of transsexual people and their families in their community; provide information and referral for peer support; provide information regarding options for gender identity and expression and possible medical interventions; help the patient to determine his/her goals and expectations, and help him or her to assess whether they are realistic. The mental health professionals can also prepare the patient for medical interventions [21].

Compulsory vs Responsible

As we are understanding from reading Latham, he suggests that people with GD, contrary to people without GD, are coerced to undertake mental assessment: "Compulsory referral of all patients seeking transsexual surgeries may violate the patient's ethical right to self-determination, to direct what happens to his/her body, and may therefore constitute a form of discrimination" [1].

Latham's statement requires clarification. Mental assessment is not *compulsory*: the law in England and in many other countries does not require it. Mental assessment is typically recommended as a part of good comprehensive care, as suggested by the SOC from the WPATH. Yet clinical guidelines are not the law and indeed the WPATH SOC are meant to provide flexible recommendations [21].

The importance of the patient's journey [26] and the integration and coordination of healthcare to achieve a better quality of care have been described [27]. Particularly for transsexual people, Monstrey et al. (2001) [28], from the University Hospital of Ghent, Belgium, emphasized the importance of the multidisciplinary approach: they concluded that a close cooperation between the different specialties within the gender team is the key to success in treating transsexual patients. Specialists such as psychiatrists, endocrinologists, plastic surgeons, urologists, and gynecologists constitute the core of the gender team, and meet with patients more frequently, while psychologists, otorhinolaryngologists, dermatologists, speech therapists, lawyers, and social workers normally see the patient more incidentally.

A multidisciplinary approach is considered important to assess quality of life before the surgery, understand patient's expectations, inform patients correctly, establish together with him/her the goals and timing of the interventions, and help the patients to go through the transition, understanding social interactions, gender roles in the society, daily activities and self-consciousness, and finally assessing the outcomes of it step by step [29].

With regard to referral to mental health professionals, in our view, its aim is not to demonstrate that there is a pathology that needs to be cured. The surgeon, in fact, is (or should be) referring the patient to mental assessment to improve the professional relationship between surgeon and patient; particularly, the mental health professional should assist the surgeon in evaluating the patient's expectations, and assessing if the surgery could positively impact the patient's life, especially when the surgeon is going to perform irreversible surgery.

Moreover, the surgeon needs to inform the patient about outcomes, risks, and limits of the surgery; however, within GRS, information should not be limited to the delivery of the list of risks and benefits of each specific procedure, i.e., vaginoplasty or any other transsexual procedure. In GRS, in fact, the surgical act is not merely reconstructing the look of a part of the body, or its function, but, far beyond that, the surgical act is aiming at reconstructing the person's identity, or part of this identity. Healthcare professionals and patients are working on the person's identity and not simply on one part of the body. Within this perspective, the participation of the mental health professional within the surgeon and patient relationship does not represent a violation of the patient's autonomy, and it is not a form of discrimination. Indeed, the patient might strongly affirm that s/he knows what s/he wants; nevertheless, the surgeon might still require the help of a mental health professional to achieve a better understanding of the patient's expectations and to explain better the limits of surgery; finally, the mental health professional can help the patient to understand how the requested surgery might impact the person's identity, and his/her relationships within society.

Some kind of pre-operative testing is performed all the times. The involvement of a mental health professional may be seen as an extension of that. As medical treatment for it has vast repercussion in the person's life, the involvement of the mental health professional is a way to help patients to cope with the significant changes that initiating treatments are going to bring to their life.

The Standards of Care

There are various international clinical guidelines providing tools to doctors involved in the care and treatment of people with GD. The most recent and authoritative are those published by the Endocrine Society in 2009 [30] and "The World Professional Association for Transgender Health (WPATH) Standards of Care (SOC)" for the

diagnosis and treatment of transsexuals, transgender, and gender nonconforming people in 2011 [21]. In the scientific literature, there is a lack of randomized clinical trials or high-quality follow-up studies on high numbers of operated transsexuals: there is no evidence-based research above evidence level B or C [22]. The WPATH is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for health of transsexual people.

The overall goal of the SOC [21] is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieve lasting personal comfort with their gendered selves, to maximize their overall health, psychological wellbeing, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, and psychotherapy), and hormonal and surgical treatments. The SOC are based on the best available science and expert professional consensus [21].

The SOC are meant to provide *flexible* guidance, to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. Although flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing GD. Clinical departures from the SOC may come about because of a patient's unique anatomic, social, or psychological situation [21].

Although the SOC are intended for worldwide use, WPATH acknowledges that much of recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes toward transsexual, transgender, and gender nonconforming people; constructions of gender roles and identities; terminologies; epidemiology; access to and cost of treatment; therapies offered; and legal and policy issues [21, 23].

Indeed, within a given country, the WPATH SOC might become less applicable either because of legal or economical issues. For example, some countries require approval from the Health Ministry (Sweden) or from the Court (Italy), and some countries do not allow gender surgery at all (most of the Arabic countries). Some countries have limited or no resources to offer complete gender treatments (within the UK, breast surgery is not offered at all for male-to-female transsexuals).

Still, the SOC are not intended to limit efforts to provide the best available care to all individuals: even in areas with limited resource opportunities, health professionals can apply the main core principles of the SOC, which include exhibit respect (do not pathologize differences in gender identity or expression); provide care; become knowledgeable; match the treatment approach to the specific needs of patients; facilitate access to appropriate care; seek patients' informed consent; offer continuity of care; and be prepared to support and advocate for patients within their social settings [21].

When it comes to mental assessment and counseling, the WPATH recommends that both prior to the initiation, and after treatment has commenced, the patient is constantly offered psychological support. Mental assessment or support is not compulsory, differently from what Latham suggests; nevertheless, mental assessment and support are, in our opinion appropriately, offered to patients through their journey. Psychotherapy is usually *offered* prior to the initiation of any medical procedure for GD patients, for purposes such as exploring gender identity, role, and expression; addressing the negative impact of GD and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience [21]. Indeed, there is no evidence to suggest that patients or a patients' group have ever complained about such an approach. It is one of the authors' experience (GS) that some of the patients might feel they do not need psychotherapy or mental counseling, but still they accept it as part of their journey, at least to have the diagnosis confirmed, and to explore what kind of further help they can be provided with, beside hormonal and surgical treatment.

As stated in the SOC, it is ideal for mental health professionals, while counseling, to periodically discuss the progress and obtain peer consultation from other professionals, both in mental health care and other health disciplines, who are competent in the assessment and treatment of GD. Further, the relationship among professionals involved in a patient's care should remain collaborative, with coordination and clinical dialog taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns [21].

Other forms of social support and changes in gender expressions can be also considered to help alleviate the suffering associated with atypical gender identity: these include peer support resources, groups, community organizations, communication therapy (verbal and non verbal), hair removal, breast binding or padding, genital tucking or penile prostheses, and changes in name and gender marker on identity documents.

Even if in specific instances, mental assessment were requested by a surgeon prior to initiation of treatment, and the patient was reluctant to undergo it, this would not mean *ipso facto* that the patient's right to non-discrimination and

his/her right to autonomy are violated: indeed, it could be argued that psychological counseling may *enhance*, rather than restrict, patient autonomy, in that it could enhance his/her capacity to make a better informed decision [31–34].

Latham [1] also reports that the postoperative dissatisfaction rate of transsexual people is much lower than the postoperative dissatisfaction rates of non-transsexual people who undertake "cosmetic" surgery. Perhaps those who explore their wishes in greater depth through mental assessment, and thus make better informed choices (where information goes beyond the provision of data relating to the clinical risks and benefits) *do better* overall.

Conclusions

Latham [1] is right in his plea for respecting the equal right of gender minorities to receive similar care as the non-transsexual population. Whereas Latham's aims are noble, it is the opinion of the authors that his arguments (i.e., leaving the choice for referral to psychiatric assessment completely to the patient) are potentially harmful toward that same category of people whose rights he proposes to defend. Referring transsexual patients for mental health counseling before surgery is not an absolute requirement, as Latham suggests. Even where the surgeon or other healthcare professionals make it a requirement, this is not necessarily violating the person's right to autonomy: on the contrary, it is improving the patient's care.

Given the variety of clinical options, and the invasive nature of some of the procedures at stake, given the implications of amending gender identities, the physicians involved may reasonably hold that they need the help of other healthcare professionals to understand the concerns of the individual patient, the goals of that patient, and to negotiate with the patient a procedure that can realistically assist the patient in achieving his/her goals.

Far from limiting the autonomy of the patient, and far from being a paternalistic attitude, this type of conduct on the part of healthcare professionals is responsible and can be seen as a part of the duty of care owed to each patient.

Furthermore, the health professional has a moral obligation to offer the best quality of care, which must be based on assessment of the patient's condition, of the expectations and goals, on provision of information regarding various options for gender identity and expression and likely risks, benefits, and outcomes of those options.

There is nothing in principle either discriminatory with proposing, or even requesting, the assistance of a mental health professionals, in cases in which surgeons or other healthcare providers may believe that this is in the interests of their patients. Indeed, they would be irresponsible if they did not, based on some abstract and misplaced idea of equality or autonomy.

Offering or requesting the assistance of a mental health professional is thus in no way a form of discrimination. If the provision of psychological care is at all a form of discrimination, it is a form of *positive* discrimination: patients with GD are given *something more*, not something less. Indeed, a surgeon may ethically request the mental assessment of anyone who applied for any procedure, if s/he reasonably believes that this may be in the best interests of the patient. If anything, from all that have been said above, it could be argued that mental assessment should perhaps be made more largely available, and perhaps sometimes requested, in a much broader range of cases.

This offer or request is also in no way an attack to the principle of respect for the patient's autonomy: it can indeed enhance the patient's autonomy. To respect *equality*, to treat people *as equal* does not mean that they should be treated *in the same way*; it means that they should be treated with the same concern and respect, but *differently*, so that they can, as unique individuals with unique needs and goals, be given *an equal* chance of attaining a life that is of value to them.

Conflict of interest The authors declare that they have no conflict of interest.

References

1. Latham J (2013) Ethical issues in considering transsexual surgery as aesthetic plastic surgery. Aesthetic Plast Surg 35:648–649
2. Salle A (2013) Transsexuals face surgery "double standard". ABC news in science. http://www.abc.net.au/science/articles/2013/05/24/3759117.htm?site=science/tricks&topic=latest. Last accessed 31 August 2014
3. Mahowald MB (1992) To be or not be a woman: anorexia nervosa, normative gender roles, and feminism. J Med Philos 17:233–251
4. Nasser M (1997) Culture and weight consciousness. Routledge, London and New York
5. Giordano S, Harris J (2005) What is gender equality in sports? In: Tamburrini CM, Tännsjö T (eds) Genetic technology and sport: ethical questions. Routledge, London and New York, pp 209–217
6. Sterodimas A, Radwanski HN, Pitanguy I (2011) Ethical issues in plastic and reconstructive surgery. Aesthetic Plast Surg 35:262–267
7. Edmonds A (2013) Can medicine be aesthetic? Med Anthropol Quart 27(2):233–252
8. Kitzinger C (2001) Sexualities. In: Unger Rhoda K (ed) Handbook of the psychology of women and gender. Wiley, New Jersey, pp 272–288
9. Giordano S (2014) Where should gender identity disorder go? reflections on the ICD-11. In: Gender identity: disorders, developmental perspectives and social implications. Nova Publishers (in press)

10. Cummings K (1992) Katherine's Diary: The Story of a Transsexual. Heinemann, Melbourne
11. Di Ceglie D (2000) Gender identity disorder in young people. Adv Psychiatr Treat 6:456–466
12. GLSEN (2011) The 2011 national school climate survey. http://www.glsen.org/sites/default/files/2011%20National%20School%20Climate%20Survey%20Full%20Report.pdf. Last accessed 9 June 2014
13. Rivers I (2011) Homophobic bullying: research and theoretical perspectives. Oxford University Press, Oxford
14. D. Di Ceglie (1998) Management and therapeutic aims in working with children and adolescents with gender identity disorders, and their families. In: Di Ceglie D, Freedman D (eds). A stranger in my own body—atypical gender identity development and mental health, chap 12. Karnac Books, London, pp 185–197
15. Haas AP, Rodgers PL, Herman JL (2014) Suicide attempts among transgender and gender non-conforming adults, finding of the national transgender discrimination survey, american foundation for suicide prevention and the williams institute, January 2014. http://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf. Last accessed 9 June 2014
16. Giordano S (2010) Sliding doors: gender identity disorder, epistemological and ethical issues. Med Healthc Philos 15(1):1–10
17. Selvaggi G, Elander A (2008) Penile reconstruction/formation. Curr Opin Urol 18(6):589–597
18. Selvaggi G, Bellringer J (2011) Gender reassignment surgery: an overview. Nat Rev Urol 8(5):274–282
19. Wroblewski P, Gustafsson J, Selvaggi G (2013) Sex reassignment surgery for transsexuals. Curr Opin Endocrinol Diabetes Obes 20(6):570–574
20. Selvaggi G, Dhejne C, Landen, M, Elander A (2012) The 2011 WPATH standards of care and penile reconstruction in female-to-male transsexual individuals. Adv Urol. doi: 10.1155/2012/581712
21. The World Professional Association for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 2011
22. Monstrey S, Vercruysse HJ, De Cuypere G (2009) Is gender reassignment evidence-based? recommendation for the seventh version of the WPATH Standards of care. Internat J Transgenderism 11:206–214
23. Winter S (2009) Cultural considerations for the world professional association for transgender health's standards of care: the asian perspective. Internat J Transgenderism 11(1):19–41
24. Dixen J, Maddever H, Van Maasdam J, Edwards PW (1984) Psychosocial characteristics of applicant calculated for surgical gender reassignment. Arch Sex Behav 13:269–276
25. Pfäfflin F, Junge A (1992) Nach untersuchungen nach geslechtumwandlung: eine kommentierte literature Ubersicht 1961-1991. Schattauer, Stuttgart
26. Layton A, Moss F, Morgan G (1998) Mapping out the patient's journey: experiences of developing pathways of care. Qual Healthc 7(suppl):30–36
27. Lillrank P (2012) Integration and operations in healthcare: an operations management view. J Integr Care 20(1):6–12
28. Monstrey S, Hoebeke P, Dhont M, De Cuypere G, Rubens R, Moerman M, Hamdi M, Van Landuyt K, Blondeel P (2011) Surgical therapy in transsexual patients: a multi-disciplinary approach. Acta Chir Belg 101(5):200–209
29. Esteva de Antonio I, Gomez-Gil E, Cruz-Almaraz M, Martinez-Tudela J, Begero T, Olveira G, Soriguer F, Grupo GIDSEEN (2012) Organizacion de la asistencia a la transexualidad en el sistema sanitario publico espanol. Gac Sanit 26(3):203–210
30. Hembree WC, Cohen-Kettenis P, Delemarre-van den Waal HA, Gooren LJ, Meyer WJ 3rd, Spack NP, Tangpricha V, Montori VM (2009) Endocrine Society. J Clin Endocrinol Metab 94(9):3132–3154
31. Bockting WO, Knudson G, Goldberg JM (2007) Counseling and mental health care for transgender adults and loved ones. Int J Transgenderism 9(3/4):36–82
32. Carroll L (2010) Counseling sexual and gender minorities. Merrill/Pearson, Upper Saddle River, NJ
33. Fassinger RE, Arsenau JR (2007) I'd rather get wet than be under that umbrella: differentiating the experiences and identities of lesbian, gay, bisexual, and transgender people. In: Bieschke KJ, Perez RM, Debord KA (eds) Handbook of counseling and psychotherapy with lesbian, gay, bisexual and transgender clients, 2nd edn. American Psychological Association, Washington DC, pp 19–50
34. Korell SC, Lorah P (2007) An overview of affirmative psychotherapy and counseling with transgender clients. In: Bieschke KJ, Perez RM, DeBord KA (eds) Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients. American Psychological Association, Washington DC, pp 271–288